September 2013

Montana Central Tumor Registry Newsletter

Montana Cancer Control Programs
Chronic Disease Prevention & Health Promotion Bureau

Collaborative Stage Changes

After a considerable amount of analysis and consideration by the national standard-setters (AJCC, CDC, CoC, NCI), Collaborative Staging (CS) will be discontinued after the diagnosis year 2015. Collecting CS over the last 10 years has proven that it is an extreme burden on hospitals and central registries. The CS system is too complex to collect and manage. It is also too expensive—over $2 million was spent in 2009 to produce CS version 2 and it will cost even more to produce version 3. The standard-setters have tried to develop a simplified CS staging system but that has not worked.

Between now and January 1, 2016, registries will be transitioning into collecting directly coded AJCC stage (both clinical and pathological TNM). AJCC has existed for a long time and is a sound organization that will continue to exist. Physicians are knowledgeable about AJCC-TNM staging and this will likely be used with Meaningful Use Stage 2 reporting from Eligible Professionals. Registries will also be collecting essential biomarkers and prognostic factors that are vital in staging.

In addition, registries will also continue collecting Summary Stage with tumor size and lymph nodes (positive and examined).

The national standard-setters such as CDC and CoC will be developing training tools for TNM and Summary Staging plus the necessary biomarkers and prognostic factors. Software vendors will also need to make necessary changes for abstracting.

Here's a brief timeline from 2014-2017. More information will be coming.

2014 (cases diagnosed 1/1/2014)
- Collect AJCC stage 7th edition and Summary Stage when available
- Define standards for reporting (data dictionary and other fields) by CDC and CoC

2015 (cases diagnosed 1/1/2015)
- Collect AJCC (required at this time for CoC approved facilities)
- Collect Summary Stage (required for all facilities)
- Train hospital and central registry registrars

2016 (cases diagnosed 1/1/2016)
- Discontinue reporting CS to NPCR or NCDB on required submissions

2017 (cases diagnosed 1/1/2017)
- Implement AJCC 8th edition

Cancer Surveillance & Epidemiology Program Staff

Laura Williamson, MPH
Program Manager
(406) 444-0064
lwilliamson@mt.gov

Debbi Lemons, RHIA, CTR
Coordinator, Montana Central Tumor Registry
(406) 444-6786
dlemons@mt.gov

Diane Dean, MS, CTR
Data Control Specialist
(406) 444-6710
ddean@mt.gov

Paige Johnson, BS, CTR
Data Control Specialist
(406) 444-6709
paigejohnson@mt.gov

Valerie Weedman
Logistics Coordinator
(406) 444-5442
vweedman@mt.gov

FAX: (406) 444-6557

www.cancer.mt.gov

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Meet the Registrar

Carol Paulsen, CTR
CAP Consulting

I'm Carol Paulsen and I've been involved with cancer registry for over 20 years. I first became acquainted with registry work when the MCTR was in its early years as a program within the State Dept. of Health & Environmental Sciences (as DPHHS was called then). My involvement with the MCTR led me to attain my credentials as an RHIT and CTR. During my employment there, I eventually held every staff position: Administrative Assistant, QA Technician and Program Manager. At one point, I assisted the Carroll College Medical Records Dept. by providing a venue for their students' clinical practice (including one student named Debbi Lemons!). In between stints at MCTR, I worked for State Unemployment Insurance, adjudicating employment and benefits issues. After 30 years, I left State employment and started my own business, CAP Consulting, and for the last 11 years have assisted many hospitals and cancer centers with abstracting and registry management.

I've served on the Executive Board of MCRA as President and Vice-President, and currently serve on the Board of Directors for the Montana Health Information Management Assoc. (MHIMA).

Montana has always been my home – I'm a Helena native. Actually, I grew up in East Helena – the big move of my life was about 5 miles from East Helena to Helena! Funny thing: one of the state offices where I worked moved into the converted St. John's Hospital building in Helena. I noticed the large windows down the hall and asked my boss what used to be in the rooms where we worked. Turned out the windows were remnants of the nursery and the rooms were previously labor and delivery rooms. I realized I was working in the same area where I had been born!

My husband, Dick, and I have been married 26 years and have 2 boys – 23 and 25. I also have a step- daughter, and 2 grandchildren who are 8 and 10. All of them live in the Helena area.

Several years ago my husband encouraged me to play golf and it's been fun ever since. We enjoy playing locally and always try to plan a golf outing when we travel. Even though we haven't hit the slopes much the last couple years, I still enjoy downhill skiing as well. I like all kinds of music – especially in the summer you can find me at local concerts and events. We have a very musical family: Dick and the boys play a wide variety of instruments and I'm a former church organist. A favorite hobby of mine is crocheting – but there's no way I can keep all the afghans I make. My friends and family all have at least one.

Now that football season arrived, you'll find me sitting in Washington-Grizzly Stadium on Saturdays, cheering for the team. Go GRIZ!

Meaningful Use Stage 2 Update

When eligible professionals in Montana begin reporting to the Montana Central Tumor Registry, the MCTR will be receiving Clinical Document Architecture (CDA) documents. The CDA is a portion of the HL7 record which includes Demographics (name, address, sex, birthdate, marital status, etc), Reporting Source, Diagnosis (date of diagnosis, primary site, histology, TNM and Summary Staging), Medical (secondary diagnoses, all text fields), Treatment (surgery, radiation, chemotherapy, etc), and follow-up (referred to, vital status, etc).

The MCTR will be using a software called eMaRC Plus (Electronic Mapping, Reporting, and Coding) which can process CDA reports (submitted electronically from the EHR) in a quick and manageable way. Right now, the MCTR uses eMaRC Plus for processing electronic pathology reports but will update the physician reporting module when the Beta testing is complete.

Incoming CDA's will be imported into eMaRC Plus, mapped from the CDA data elements to the NAACCR standard data codes and format. The advantage of using eMaRC Plus is that when multiple records are submitted for the same patient and the same cancer, the software is smart enough to know how to consolidate all the records into one complete comprehensive record from the physician. One unique report can be exported from eMaRC Plus and imported into the MCTR database.

The MCTR will be developing procedures for incorporating reports such as these into the MCTR database to determine the best time to export each complete record out of eMaRC Plus. Each record (or set of multiple records) will only need to be processed and exported one time.

Certificate of Excellence Recipients

The following facilities received a certificate for the 2013 Second Quarter, acknowledging their timeliness in reporting. Ninety percent of their cases were reported within 12 months.

Facility	City
Physicians:	
Rogers Dermatology	Bozeman
Advanced Dermatology of Butte	Butte
Dermatology Assoc of Great Falls	Great Falls
Associated Dermatology	Helena
Helena Dermatology	Helena
Dermatology Associates	Kalispell
Mark Stewart Dermatology	Missoula
Hospitals:	
Big Sandy Medical Center	Big Sandy
Billings Clinic	Billings
St. Vincent Healthcare	Billings
St. James Healthcare	Butte
Teton Medical Center	Choteau
Sletten Cancer Center	Great Falls
Northern Montana Hospital	Havre
Kalispell Regional Medical Center	Kalispell
Central Montana Medical Center	Lewistown
St. Patrick Hospital	Missoula
Clark Fork Valley Hospital	Plains
Ruby Valley Hospital	Sheridan

ICD-O-3 Changes

Changes effective January 1, 2014

Use the following new terms, synonyms, and related terms for existing ICD-O-3 codes

New preferred term	8150/0 Pancreatic endocrine tumor, benign (C25._)
Move former preferred term to synonym	8150/0 Islet cell adenoma (C25._)
New related term	8150/0 Pancreatic microadenoma (C25._)
New preferred term	8150/1 Pancreatic endocrine tumor, NOS (C25._)
Move former preferred term to synonym	8150/1 Islet cell tumor, NOS (C25._)
New preferred term	8150/3 Pancreatic endocrine tumor, malignant (C25._)
Move former preferred term to synonym	8150/3 Islet cell carcinoma (C25._)
New related term	8150/3 Pancreatic endocrine tumor, nonfunctioning (C25._)
New related term	8152/1 L-cell tumor
New related term	8152/1 Glucagon-like peptide-producing tumor (C25._)
New related term	8152/1 Pancreatic peptide and pancreatic peptide-like peptide within terminal tyrosine amide producing tumor
New synonym for related term	8152/1 PP/PYY producing tumor
New preferred term	8154/3 Mixed pancreatic endocrine and exocrine tumor, malignant (C25._)
New related term	8154/3 Mixed endocrine and exocrine adenocarcinoma (C25._)
New synonym for related term	8154/3 Mixed islet cell and exocrine adenocarcinoma (C25._)
New related term	8154/3 Mixed acinar-endocrine-ductal carcinoma
New related term	8201/3 Cribriform comedo-type carcinoma (C18._, C19.9, C20.9)
New synonym	8201/3 Adenocarcinoma, cribriform comedo-type (C18._, C19.9, C20.9)
New synonym to primary term	8213/0 Traditional serrated adenoma
New related term	8213/0 Sessile serrated adenoma
New related term	8213/0 Sessile serrated polyp
New related term	8213/0 Traditional sessile serrated adenoma
New related term	8240/3 Neuroendocrine tumor, grade 1
New related term	8240/3 Neuroendocrine carcinoma, low grade
New related term	8240/3 Neuroendocrine carcinoma, well-differentiated
New preferred term	8244/3 Mixed adenoneuroendocrine carcinoma
Move former preferred term to synonym	8244/3 Composite carcinoid
New synonym	8244/3 Combined/mixed carcinoid and adenocarcinoma
New synonym	8244/3 MANEC
New synonym	8249/3 Neuroendocrine tumor, grade 2
New related term	8249/3 Neuroendocrine carcinoma, moderately differentiated
New synonym	8263/0 Tubulo-papillary adenoma
New related term	8290/0 Spindle cell oncocytoma (C75.1)
New related term	8490/3 Poorly cohesive carcinoma
New related term	8811/0 Plexiform fibromyxoma
New related term	8970/3 Hepatoblastoma, epithelioid (C22.0)
New related term	8970/3 Hepatoblastoma, mixed epithelial-mesenchymal (C22.0)
New related term	9471/3 Medulloblastoma with extensive nodularity
New related term	9474/3 Anaplastic medulloblastoma
New related term	9506/1 Extraventricular neurocytoma